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ABSTRACT

The author reviews current practices in the educational diagnosis of exceptional children and proposes a model for more effective identification, screening, and evaluation of students with special needs. Problems and benefits of models in current use (multidisciplinary team approach, the training based model, and the psychometric approach) are delineated. The multidisciplinary approach is said to foster linear rather than collaborative services. The psychometric approach is seen to penalize for cultural and social differences and to defy principles of least restrictive environment and due process. The author suggests a change in philosophy to effectively implement the multidisciplinary team approach in a therapeutic school environment with defined roles for ancillary staff. (CL)

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Diagnosis and Treatment:
Contemporary Practices in Special Education

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The study and practice of special education are best with rampant controversies. The most profound are opposed conceptions of special services. In this regard, there are unsettled issues as to what should indeed be the interrelationship among special service personnel, the regular classroom teachers, students and parents. There are those who argue that most if not all of the modes of interrelationship among these sectors are obsolete and unjustifiable (Dunn, 1968; Lilly, 1970; Lilly, 1971). There are those who assert that special education has been vulnerable to criticism primarily because of its use of special service personnel, particularly the school psychologist, to define special education on the basis of different categories of exceptionalities as well as by using highly loaded negative terminology (Williams, 1970; Balow and Reynolds, 1972). Others say that the shortcoming of special education is the emphasis it places on administrative and organizational arrangements virtually to the exclusion of a program which offers diversification or alternatives (Adamson and Van Etten, 1972). In essence, all of these issues address the efficacy of traditional approaches to educational diagnosis and treatment of children so classified as "exceptional."

The purpose of this article is threefold. First, it gives a descriptive overview of contemporary diagnostic and treatment practices in special education. Since both educational diagnosis and treatment are viewed as ongoing and conmitant processes (Elkins and Taba, 1968; McLoughlin and Wallace, 1975), and since diagnosis per se should pave the way to an intelligent educational treatment plan (e.g., crisis intervention, remediation, prevention), considerable attention is devoted to current diagnostic procedures. Second the most provocative special education model is discussed in terms of its implications for change in the manner of delivering special services to children traditionally classified as either educable mentally retarded, emotionally disturbed, educationally handicapped, behaviorally disordered, learning disabled, or brain injured. Finally, an alternative is suggested as a more practical means of effectively implementing the multidisciplinary team approach in identifying, screen-

ing, evaluating, and remediating conflict oriented situations which impact on the psycho-educational growth and development of children in the general school environment.

It should be understood, however, that it is not the writer's intent to present his position as the only means of dealing with the issue of what should be the role of supportive services in special education. Rather, it is intended to give clarity and meaning to contemporary diagnostic and treatment practices in special education and to establish the potential of the Multidisciplinary Team approach as a viable means of fostering optimum social, emotional and academic skills of a wide range of children so classified as "exceptional."

Contemporary Practices

Special education literature makes reference to two basic procedures to educational diagnosis of exceptional children. One is the most rarely used multidisciplinary team approach,¹ and the other is the most frequently used psychometric approach (Dunn, 1968).

Theoretically, the multidisciplinary team approach is quite sound for it is built on the basic principle that the child being diagnosed and treated characterizes an intellectual, social, psychological, physical and spiritual being who grows and matures in relation to all of these factors. In practice, this method calls for the involvement of a cadre of specialists from varied disciplines (e.g., social worker, teacher, school nurse, truant officer, speech and language specialist, pediatrician, psychologist, and psychiatrist), all of whom are to bring their individual knowledge, skills and insights to bear on effecting change in the symptoms or problems that interfere with the child's educational process.

¹ The multidisciplinary team approach is often referred to as the collaborative approach or the team operation. It is in theory a process wherein each member of the evaluation team makes its distinctive contribution to the overall assessment profile and program development for the child.

Through diagnosis of the whole child in relation to symptomatic behaviors, the foremost consideration of the multidisciplinary team approach focuses on the provisions of appropriate clues and techniques for educating exceptional children (Force and Garrison, 1959). Also adherence to this approach demands attention to the outcome of prescribed treatment (Peter, 1965).

In spite of the laudable, challenging and pragmatic characteristics of the multidisciplinary team approach, its misuse prevails in educational settings. The most obvious abuse is that the services "exceptional" children (i.e., particularly those classified as developmentally disabled and/or emotionally disturbed) receive from the various specialists are generally linear rather than collaborative. The linear procedures are best described in the following passage by Peter (1965):

In practice the progression from teacher to other resources varies from one school system to another, but the direction is usually the same. The child presenting the problem is referred by the teacher to the school administration or counselor, then to the school psychologist, school social worker, school nurse, child guidance clinic, social agency, or psychiatric clinic. The resources vary, but the movement is always out or away from the classroom (p. 3).

The type of linear practice described above has left special education vulnerable to attack from parents, children advocate groups, and judicial and legislative systems at both the state and federal levels. The criticism levied largely stems from the omission of certain fundamental characteristics of the multidisciplinary team approach during the evaluative-treatment process. First, the linear practice makes no allowance for the continuous involvement of the teacher in an ongoing evaluative-treatment process of "exceptional" children. This is because once a troublesome child is referred to the school psychologist, the prevalent feeling among teachers is to remove the child from the regular class and never to return. Moreover, there is a prevailing tendency among teachers to discontinue their assessment of an instructional program for the "problem" child until such time that psychological recommendations have been made. This mode of teacher behavior is what Johnson (1976)

called "an educational holding pattern" for the child. He amplified the point in the following way:

By making this rather simple step, the teacher is generally divested of further major responsibility for ensuring improved programming for the student in question. By and large, the teacher conducts business as usual, and the student receives few program modifications while evaluation is pending. In a sense, the teacher shifts the burden of responsibility by making the referral, and the student goes into an educational holding pattern pending "expert" evaluation (p. 48).

The omission of continued or complete teacher involvement beyond the point of the initial referral is followed by the omission of a sound practical manner of giving priority to multisupportive services children may indeed require. In essence, the linear practice makes direct referrals to a given discipline without the involvement of other team members (e.g., social worker, teacher nurse, parent, etc.) in an initial screening, assessment and decision making process. If other team members become involved, it is generally after the case has been referred by the team member. This indirect way of referring precludes the need for initial screenings or reviews of possible or known multiproblem cases which may need initial consideration by more than one discipline. Furthermore, it lends itself to fragmented and unnecessary duplication of supportive services in that each team member rarely knows what the other is doing in relation to similar cases.

From an empirical perspective, several conclusions can be drawn from the linear practice: (1) Since the psychological evaluation is usually the first service provided in the team approach, obviously the emphasis is shifted from a need to priority supportive services for the purpose of planning and carrying out the best educational program for the child to a focus on the administration of a psychometric battery for the purpose of labeling the child and the subsequent placement in a special education classroom or facility. (2) Generally, the health history or current medical status of the child is not considered as being essential prior to the administration of a psychological evaluation. Most frequently, medically based problems are not suspected or recognized until after the child has been seen by the

psychologist. This in itself places the validity of the psychological examination in question, and it certainly has serious implications if in fact the child is subsequently programmed inappropriately. (3) With psychological services viewed as the criteria for placing children in special classes or programs, social services are often played down in such manner that they are not directed toward dealing effectively with the handicapping consequences of chronic social conditions or situations but rather the cause of problematic social and academic behaviors. In summary, we might say that the linear practice of the multidisciplinary team approach represents at best a state of ignorance or deliberate omission on the part of those persons responsible for providing supportive services and school administrators charged with the responsibility of assuring that the services and programs provided to "exceptional" children are non-biased and appropriate.

The psychometric approach to educational diagnosis and treatment cited does not differ significantly from the first approach. However, the major thrust of the psychometric approach centers exclusively on the administration of psychometric test and subsequent recommendations. In this instance, seldom is there involvement or input from other disciplines. The psychologist is asked to provide not only psychological data but also social and medical input data. Within the context of psychometric tests, this approach encompasses the administration of individual intelligence and achievement tests along with social, health history and personality assessments.

As a means of clarifying the psychometric approach, Johnson (1976) identified several steps associated with this approach. Step one he called the "red flag" component. It is virtually the same as the initial step of the multidisciplinary team approach, for it simply requires the teacher to identify aberrant academic and/or social behaviors and make the referral to the school psychologist. Nonetheless, certain characteristics are exemplary of this step. First, the identified academic and/or social problems or symptoms that seem to be impeding the normal educational

functioning of the child are generally obtained in a helter-skelter fashion. This is evidenced by the fact that seldom is the deviant behavior of the child monitored to determine at what times and under what circumstances and conditions certain behavior occurred. In addition, the referral information is usually expressed in vague or general terms. For example, "Johnnie fails to achieve at expected level. He is hostile, aggressive and relates poorly with his peers."

Second, psychological referral data often reflect undesirable behavior taken from cumulative folders. In this instance, the teacher acts as a historian by recording past rather than current behaviors.

If not more crucial than the first step, the second step is at least just as crucial. This step constitutes the actual transmittal of the psychological referral to the principal or the administrative referral designee. As the monitor of the process, it is desired that the principal or his or her designee use this opportunity to make appropriate decisions about the action being requested.

Johnson (1976) presented a somewhat pessimistic view of administrative behavior at this step of the psychometric approach. Cogently he stated:

Although one can think of many individual principals who at this point in the referral system exercise major creativity in attempting to program for the individual within the limits of general education resources and staff, there are many who do not do so for whatever reason (p. 48).

Since the general feeling among educators is that the school psychologist's major function is to evaluate children for possible special education placement, we can infer from the statement above that a great number of "special" education students are not receiving the least restrictive alternative program.

The third step constitutes the "gatekeeping" phase of the psychometric approach. It is so-called by virtue of the fact that the school psychologist, by law and public sanction, has the sole authority to determine the eligibility of most exceptional children for special education programs and facilities. Paradoxically, current statutory requirements mandate the involvement of multidisciplinary personnel

in determining the most appropriate type of educational program for exceptional children. Yet, the intelligence quotient, achievement scores, and level of personality functioning obtained from psychometric tests are used as the cornerstone for "special" education placement and decision making.

From an analytical perspective, many criticisms have been levied at the traditional psychometric approach. The major complaint is that it penalizes the child because of his or her cultural and social differences and that these differences are not reflected in psychometric evaluative instruments constructed on the norms of the dominant social order or system (Cohen, 1969; Williams, 1970; Kleinfeld, 1973). In other words, the most frequently used psychometric instruments (e.g., the WISC, Binet, Bender-Gestalt, Illinois Test of Psycholinguistic Abilities) do not adequately assess the exceptional child's adaptability to not only the school but also the home and neighborhood communities (Nazzaro, 1976). To this point, the Bureau of Education for the Handicapped has sharply stated:

An assessment ... should be made of the child's adaptive behavior in the school setting based on observations and records, and, where appropriate the use of adaptive behavior scales. Information from the home should include (1) the child's adaptive behavior in the home, community and neighborhood, as perceived by his parents or guardians or principal caretakers, (2) the sociocultural background of the family, and (3) the child's health and developmental history (p. 28).

Moreover, the limited function of the psychometric approach is cited in a study by Mercer (1975) in which it was found:

....that most community agencies, especially the public schools, were relying mainly on measures of "intelligence" in "diagnosing" mental retardation. Ninety-nine percent of the labeled retardates nominated by the public schools had been given an intelligence test, but only 13 percent had received a medical diagnosis. The only measure of "adaptability" was implicit... No community agency systematically assessed the child's ability to perform complex nonacademic tasks in his home, neighborhood, and community. Assessment procedures were unidimensional. They focused only on the narrow band of behavior sampled in the psychometric situation... (p. 143).

Fundamentally, Mercer advocates a "multidimensional" assessment of the child -- one which focuses on the child in terms of the norms of social systems other than those

represented by the clinician, psychologist, teacher and school.

Another important criticism of the psychometric approach is that it defies both the principles of "least restrictive alternative educational placement" and due process. The first principle is opposed in that the key purpose of the psychological evaluation is to determine the eligibility of the child for some type of "exceptional" program usually outside of the regular classroom. Significantly, eligibility is predicated on labeled behaviors and academic and intelligence tests scores which indeed program the child for a specific kind of educational track under the egis of special education. Crucial to this point is the fact that a great number of students are caught in the tracking system where many of them do not belong and few of them find their way out. This fact is congenly evidenced in an excerpt from Walden's (1975) summary of the Hobson v. Hansen controversy on the use of the tracking system in the Washington, D. C. School System. The excerpt follows:

Perhaps even more damning to the school district's case was the closed nature of the tracking system. The court found that children were placed in tracks as early as the fourth grade and were rarely able to move from a low track to a higher one... The rigid operation of the system, together with the lack of equal educational opportunity implied in the differential curricula, caused the court to rule that the tracking system resulted in an inferior educational system....(p. 81).

The second principle, due process, is denounced within the context of the psychometric approach in that this approach restricts the involvement of many disciplines needed to adequately and thoroughly assess the social, emotional and academic performance of "exceptional" children and to make appropriate recommendations for them. Also this approach denounces due process inasmuch as it does not express both strengths and weaknesses of the child but rather general statements, scores and labels about the child's academic, emotional and social functioning. The gross omission is that little relevant information is given about the nature of the child's learning style or the manner in which he or she learns best.

Finally, the psychometric approach promotes diffused accountability. This

occurs under three different conditions: (1) when psychological services are curtailed because of a backlog of referrals, (2) when such services have been completed but the formal evaluative report has not been submitted to the principal, and (3) when placement recommendations based upon the results of the evaluation are difficult to obtain. The inherent problem in each of these conditions is the shifting of accountability among those persons charged with providing the services. For example, the teachers most often take the attitude that there is little they can do for the child until such time that their reasons for referrals are either endorsed or debunked by the school psychologist. Also, the failure of the school principal to exercise creativity in seeking alternatives for educating the "exceptional" child within the regular classroom setting is another example of diffused accountability. This point is evidenced by the fact that many students with emotional and/or social difficulties are frequently suspended from school only to return with the difficulties having escalated.

Shortcomings and Liabilities: Implications for Change

Obviously the shortcomings, liabilities and limitations in both the multidisciplinary and psychometric approaches suggest a need for change in current educational diagnostic-treatment practices. In response to this need, new service delivery systems have been proposed to replace the traditional special service model in special education. The most provocative is Lilly's (1971) training based model which was built on the rationale that most of the problems associated with current educational diagnostic-treatment practices can be largely attributed to the ways in which educators and supportive special service staff conceptualize and treat children so classified as "exceptional". Prior to this time, Lilly (1970) had recommended a shift of "emphasis from exceptional children to exceptional situations in school." He explained his posture in the following manner:

An exceptional school situation is one in which interaction between a student and his teacher has been limited to such an extent that external

intervention is deemed necessary by the teacher to cope with the problem (p. 48).

According to Lilly (1971), the effectiveness of this new focus would require some fundamental changes. The first would be the establishment of a zero reject model which says that "...once a child is enrolled in a regular education program....it must be impossible to administratively separate him from that program for any reason." This in effect places the responsibility for the child's failure directly on the teacher. The second change would demand the teacher to take full responsibility for rectifying the classroom situation. Both of these changes lead to yet a more important change. It is the demand for a special education service model that has as its aim:

....the enhancing of classroom teachers' skills to the point that problem situations in the classroom can be handled adequately by the individual teacher without resorting to complex (or even simple) networks of outside support service. In other words, our goal is to make teachers self sufficient, able to handle problems rather than refer them (p. 746).

Essentially, the training based model attempts to remove special educators and special service personnel (e.g., itinerant teachers, school counselors, adjustment teachers, resource teachers, school psychologists, psychiatric social workers, psychiatrists and etc.) out of the role of direct services to children in exceptional situations. In this regard special educators would function exclusively in the tutelage capacity to the classroom teacher (Cartwright and Cartwright, 1972). Implicit here is the notion that the classroom teachers' mode of interpersonal relationships, classroom management techniques, instructional and educational diagnostic skills would become the focus of the educational program for exceptional situations. In other words, the emphasis should be placed on what things teachers do and when and how they do things to enhance the educational diagnostic-treatment process.

While one would hardly argue in total against the training based model, one can certainly point to aspects of the model that are questionable in terms of appropriate modes of change. For example, although the writer agrees with the concept of exceptional situations in special education settings or the regular classroom,

he questions the notion (1) that there is nothing inherently good in any of the traditional diagnostic-treatment practices or service models, and (2) that therefore all old models, special classes, diagnostic prescriptive programs, resource programs, itinerant services should be discarded. This posture has been denounced by Adamson and Van Etten (1972). Basic to this position is the crucial reality that "professional educators insist on not utilizing known successful ingredients, desiring to submerge all that is known and 'start over'".

From the writer's perspective, any across the board abrupt and radical change in approaches to special education would prove impractical and inimical to the best interest of children in need of special education instructions and services. However, be assured that this does not mean to imply that there is no need for change or that change, if needed, should not take place as rapidly as possible. What it means is that we must assess those programs, models, and strategies we now have and determine the underlying reasons as to why they are not effective if this is indeed the problem. We must also recognize the fact that the field of special education is multifaceted and interdisciplinary in nature and scope and that many school systems that have special education programs and related services are too large, complex, bureaucratic and imbued with social, political, and economic problems which impact heavily on such programs and services. Consequently, we would be leading our children in need of programs and related services down a cul-de-sac if we accepted a single program or service model as the panacea to solving all of the problems in special education.

Therefore, what is being proposed here is the notion that the multidisciplinary team approach has the potential for becoming an effective means of providing diagnostic-treatment services to a wide range of students with mild to severe difficulties and who are further handicapped by virtue of their involvement in exceptional school situations in large urban school districts. Moreover, what is being proposed is a framework wherein the multidisciplinary team approach can be more effectively

implemented. This framework calls for changes in three fundamental areas of educational program provided to children in need or potentially in need of special education instructions and/or related services.

Philosophy

First, there must be a change in the school district's philosophy which governs the manner in which children are identified, screened, and evaluated for special education programs and related services, and how these children's difficulties are remediated. Each school district must establish and promote the philosophy that all education is indeed special and that both the students and teachers as well as the parents are unique individuals. The basic tenet of this philosophy is that the types of programs and related supportive services received by students with mild to moderate academic, emotional and social difficulties do not in any way suggest and warrant the removal or isolation of these children from the general school program. Each school district must also adopt the philosophy that the provision of supportive staff (e.g., instructional specialists, psychologists, psychiatric social workers, and etc.) is to enable the students and teachers confronted with exceptional or potentially exceptional situations or needs to better understand and cope with the reality of themselves and all that constitutes the educational environment in which they must collectively interact. However, this philosophy must be undergirded by the following principles:

1. Children are learners endowed with multiple characteristics; therefore, any attempt at identifying, screening, evaluating, and remediating their needs can best be achieved by utilizing the collaborative multidisciplinary team approach.
2. All persons who have a direct bearing on the child's psycho-educational growth and development must become involved in discovering and sharing pertinent knowledge, information and skills that will enhance the child's educational achievement.

3. Labeled behavior (e.g., truancy, withdrawal, hyperactivity) is only symptomatic of a problem. Therefore, emphasis must be shifted from defining labeled behaviors as the problem to defining such behaviors as symptomatic of a problem. Thus, the term problem must be redefined as conflict either between the child and himself or herself, the child and peers or siblings, the child and authority figures.
4. Psycho-educational diagnosis and remediation are concomitant processes which should unfold the strengths and weaknesses in the child's academic, social, and emotional functioning, life and learning styles.
5. Appropriate and accurate diagnosis should unfold appropriate strategies for programming learning experiences, for establishing learning modalities and for determining the best type of reward and feedback each child needs for positive learning reinforcement.
6. Provided that appropriate subsequent steps are taken to program the learning process, knowledge of the child's strengths should facilitate the learning process.

By adopting the philosophy and principles stated above, this will aid significantly in placing a moratorium on the proliferation of indiscriminately identifying, evaluating, labeling and placing children in isolated and segregated special education programs and facilities purported as being of benefit to children so classified as being mentally retarded, behaviorally disordered, emotionally disturbed, educationally handicapped, learning disabled, or brain damaged.

Establishing and Maintaining the School as a Therapeutic Milieu

The second essential ingredient in the framework for effectively implementing the multidisciplinary team approach calls for a drastic shift from both the child centered and the teacher centered approaches to a psycho-education program which focuses on a therapeutic school environment. This change would require that the total

work force (e.g., general teachers, teacher specialists, psychologists, psychiatric social workers, teacher nurses, teacher aides, speech and language specialists, bus attendants, lunchroom staff, mental health workers, and etc.) who have direct involvement with the students during any phase of the educational process acquire sufficient knowledge, understanding, and acceptance of the students. This in essence means that the total school must become an environment where the tone and balance of group and individual interaction are paramount. Here the development of socialization skills are encouraged through interaction with peers, parents, administration, and a diversified staff. This concept places the demand on all persons within the educational environment to establish and maintain the reality focus of school as a place for learning (Morse, 1958). Moreover, within this context all persons including the students must be required to contribute significantly to the management of social and emotional behaviors. In order to attain this objective, standards of school behavior and performance must be established with and sanctioned by the students, parents administration and staff.

Redefining the Role of Ancillary Staff

The third area of change needed to effectively implement the multidisciplinary team approach is that the roles of professional ancillary and paraprofessional staff must be redefined. The redefinition of roles would require that within the framework of each persons primary responsibilities, he or she would have the joint responsibility of assisting the classroom teachers in identifying, screening, evaluating, and remediating difficult or potentially difficult social, emotional, and academic related situations that occur within the classroom and school environment. The primary mode of assistance to the classroom teachers must be a genuine level of understanding, acceptance and skills. Professional ancillary staff such as school psychologists, psychiatric social workers, and speech and language specialists would also be required to become more directly involved in diagnostic-prescriptive teaching rather

than devote their time exclusively to diagnostic testing and interviews. For example, psychiatric social workers or mental health specialists and psychologists would have the responsibility of providing the formal clinical component to the educational program. They would also assist teachers and parents in screening exceptional situations to determine the appropriate course of action to be taken. In essence, their additional responsibility is to assist the teachers in carrying out activities that will accomplish instructional goals related to the affective domain.

Another significant change would come about in the manner in which the instructional specialist and master teachers are used. Their traditional consultative role would become more direct they would now be required to observe teacher and student interaction during the various learning situations and assist in diagnostic teaching to prescribe and provide special instructional methods and materials to the teacher. From their observations and ongoing evaluations of the teacher and pupil interactions, they would advise the teacher of the ways to make adjustments within the classroom. While in the classroom, the instructional specialist would have the responsibility of providing educational diagnosis, tutoring, and small group instructions.

Conclusion

This article has evidenced that the traditional users of the multidisciplinary team approach lack uniformity. The approach has been used helter-skelterly without any sense of direction and purpose. Moreover, the users of this approach have employed intuitive skills exclusively, and the persons involved in diagnosis and treatment generally reflect a great deal of confusion in their attempts to respond to even the most rudimentary academic, social and emotional problems within the formal educational setting. Based upon these observations, the mandates of Section 504 of the 1975 Rehabilitation Act, and the guidelines of Public Law 94-142, it is obvious that educators and clinicians have the arduous responsibility to assure that together they formulate a practical conceptual system for understanding the psycho-educational problems they and their students encounter during the educational process.

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